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About our cover . . .

Captain Sylvester Lee and his family on their way to church in Tokyo. Tenth of a series of Journal covers on family life . . . photograph courtesy U. S. Army.

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Battle Field . . . Blood Bank

Five people stand in a blood bank line.

Bill, in uniform, straight from Korea. He is living today because the blood of someone else is flowing in his veins.

Mollie, young and earnest, a real doll. She wants her blood set aside for the personal use of her fighting boy friend, should he need it.

Sam, burly defense worker, bond buyer and veteran blood donor. He boasts that one corpuscle of his good red "burgundy" will keep a man alive indefinitely.

Robert Smith, portly, pin-striped symbol of respectability. He gives his office workers time off with pay to go to the blood donor center.

Donna Kane, housewife, mother of two GIs. She says very simply, "It makes me feel better."

Patriots all, they know their share is an important one, but trifling compared to the all-out sacrifice of the fighting man. What they don't consciously realize is that by living clean lives, they are able to give **good** blood, blood that can be used to vitalize the wounded. As good citizens, as worthy family members, as donors, they are able, too, to contribute toward that way of life that the GI is fighting for, and that he hopes to come back to someday.

America's fighting strength and America's future are safe in their hands.

TOMS RIVER LOOKS BACK — 1951-1941

A Family Relationships Course in Perspective

by Elizabeth S. Force

Ten years have passed since the Family Relationships course was introduced in Toms River High School. During that time slightly fewer than 1,000 junior and senior boys and girls have "taken" Family Relationships.

It would be gratifying to be able to say that as a result of this addition to the curriculum all sin, divorce, broken homes, marital unhappiness and mental suffering have been banished from Toms River and particularly from the lives of those happy few who together diligently considered ways and means of establishing strong, united, happier homes. Obviously we are able to make no such extravagant claims. Even modest claims are difficult to substantiate, although with a clear conscience we can *claim* more than we can *prove*.

The assumptions upon which the course were originally based were simple:

- Young people prepare themselves for all kinds of vocations by study, observation, experience, practice.

- Establishing a home and rearing children are the most vital of all vocations.

- Almost all boys and girls in the school eventually marry, establish homes and rear children.

- By study, observation and experience a certain amount of valuable learning can take place that will help them to do both jobs at least a little better than they might without any special training. We were certain the school could help them *a little* . . . we *knew* we could not do it *all alone!*

- We agreed with the writer who stated, "We will never have a much better world until we have happier marriages, happier homes, happier and more emotionally stable children."

Subversive Propaganda

We blithely disregarded four sinister and subversive rumors to the effect

- That boys and girls of 16, 17 and 18 were already "jelled" and inflexible, with habit patterns so rigid that changes in attitudes, points of view and behavior were unlikely to take place in any significant measure; therefore

- That by the time these young people reached their late teens our meager, well-intentioned offerings would prove to be more than likely too little and too late.
- That, anyhow, attitudes, ideals and ideas concerning love, marriage and parenthood were not *taught* but *caught.*
- That family life and sex life were practically synonymous.

We proceeded on the convictions

- That growth and learning are inevitable and continuous processes.
- That *no* learning can come too late, no matter how little there is of it.
- That in any event the thing was worth a try. What was there to lose?

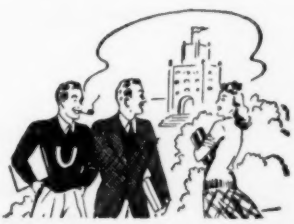
What It's All About

Our concept of what Family Relationships was all about was perhaps naive, but firmly held.

- We held that Family Relationships was pretty much an "above the belt" matter.
- That what happened *in* and *to* the heart and head (emotions and intellect) mattered more than what happened *in* and *to* the pelvic region.
- That the three areas were without doubt interrelated.
- That sex education was really *character* education.

At once then the course leaned *away* from the emphasis on sex (as the word was then understood by the general public) and leaned instead *toward* the personal relationships and mental hygiene aspects of family living.

The community was a friend to the school.



There is little doubt that this choice of emphasis or slant saved us from some community censure, misunderstanding and perhaps eventual conflict. Our school system was on good terms with the community. We therefore proceeded on the belief that it was a *wise* (not an "ornery")

community that kept its finger in the school curriculum pie. We were happy to work within the framework provided for us, a framework that permitted ample freedom and imposed no crippling limitations.

They Knew They Had a Good School

The excellent community-school relations were not an accident. A dynamic, creative leader, backed by a gifted and far-seeing Board of Education, had already upon several occasions demonstrated to the town fathers and mothers the value of other hitherto untried educational ventures. The taxpayers philosophically gave us the green light to go ahead with our newest notion. There was no mass meeting, no committee of representatives from organizations, no fuss nor fanfare.

It was really quite simple. The people knew they had a good school. They knew the school had an able leader and a reliable Board. They respected the faculty and trusted the educators to "do their stuff." In other words, past school performance had won confidence and goodwill.

A successful start was essential if the course was to click. We could not risk having it blow up in our faces. We were willing to go slowly, respecting the problem that was involved in handling in a public school situation so personal and delicate a topic as the family, which to each student immediately became (unconsciously) *my* family. New trails had to be blazed. Discretion and conservatism were the watchwords. Confidence had to be maintained.

"Home work"—
the whole family
discusses
class problems.

Interpretation had to be made so that when the family gathered around the supper table at night the ideas gathered through class discussion would be relayed with reasonable accuracy. To this end, problems that could be shared with friends and family were selected for discussion.

Reading matter was carefully screened and chosen so that it too could be safely shared with others who were not so close to the course.

Let the Community In

Community interest in the newfangled course ran high. Civic groups, service clubs and all types of organizations clamored for a speaker who could give them "the lowdown." The teacher and the principal addressed many such groups. Question periods at the end of the sessions provided a clearing-house for further exchange of ideas.

Whenever a group of Family Relationships pupils accompanied the speaker, they were royally received. Their candid views and challenging remarks amazed and delighted the adults. Even the most hidebound Three-R devotee could not refrain from responding to the sincerity, spontaneity and eagerness of the glowing young adults who in no uncertain terms spoke their minds on family and personal issues that affected them. No punches were pulled on either side. Mutual respect increased as a result of these meetings, for the young people too were impressed with the attitude of the adults.

"I didn't know that parents could be so intelligent!" remarked one astonished youth after one stimulating session.

The Aims Are Understandable

In establishing any course, and particularly this kind that reaches into the very heart of the home with its promises and its threats, it is necessary to have reasonable and acceptable goals. The goals must be expressed in language free from the pedagogical hocus-pocus that almost always throws up a smoke-screen between the educator and the public.

Marriage to her is no longer a billowy dream.

The positive aims of the Family Relationships course were stated thus: Through this study it is hoped

- "That boys and girls in the young adult group (we did not use the misused word *adolescent*) will consider the seriousness of establishing a good home and family.
- "That they will face the opportunity more hopefully, realistically and happily, having had some preparation.

- "That they will be able to contribute positively to their present family situation, using the insights and skills and knowledges they acquire through the course."

The devout hope was expressed that as a result of the Family Relationships course, there would be:

- Fewer divorces
- Fewer broken homes
- Less delinquency
- Less unhappiness among children and parents.

Mutual Support in Home and School

In explaining the goals, it was essential to make clear to the mothers and fathers *and to the students* that the purpose of the course was to *supplement* the foundation laid by the home, not to *supplant* it, which, of course, would be impossible anyhow. We never lost sight of the fact that each boy and each girl enrolled came not from a vacuum but from a home which had its own special culture, philosophy, religion, attitudes, ideals, standards, class pattern, loyalties, etc. We did not *try* to replace, substitute or exchange for these a set of ready-made principles of living and patterns of thinking which we considered to be preferable or superior.

She likes
her family
better
than ever.

Nothing could be more damaging to family relationships than to withdraw from the home the support that it badly needed. In as many ways as possible we tried to give continuity to the home's purpose and point of view. Wherever we could, we tried to supplement. Our goal was to send each student back to his family thinking *more* of it, not less . . . *understanding* his family, not condemning it . . . willing to work to help his family, not wishing to wash his hands of it.

We Convert Our Critics

What about the critics? Anticipating difficulties may not always be wise, but we tried to forestall misunderstanding. We invited potential critics into the class and gave them a job to do. Specific questions were turned over to them for discussion. We put them to work with a small group of students.

Intimacy was effective. *We have never failed to convert a critic when he finally and fully comprehended our goals and our purposes and understood our techniques. Everybody* was in favor of establishing *strong, united, moral* family life. No one objected to that aim.

We found and won key people. They helped us immeasurably. We got parents in on the homework whenever possible. We helped pupils interpret what they learned to others. We took them into our confidence. We told them *why* adults were likely to be puzzled as to the purpose and merit in any new field of study. We helped them to sell! We checked and double-checked on what was taught and helped the students meet unfair and unjustified attacks when they were made.

The students, after all, are the *only*, the *best* and the *final* line of defense. They can sell or kill the effort. If they find the course helpful and useful, they'll fight to save it, as ours have done upon occasion. In our community, a few times it has been necessary to reinterpret goals and values for the benefit of newcomers who failed to understand our purposes.

"How can we get the study of the family in *our* schools?" is a common question, and a tough one to answer.

To tell other communities exactly how to initiate studies of this type into their schools is impossible, for each school and community has its own peculiar situations and problems. In general, four types of approaches have been tried.

There Are Approaches and Approaches

Type number one is direct, honest, hearty, fearless. It says, "Here's a good idea. Let's try it today, next week or next fall." Then the plunge is made. One is reminded of the dive made by the reckless adolescent who dashes down the springboard, leaps into the air with abandon and—holding his nose tightly for protection—lands with a splash in the pool below. This is a risky approach. No finesse, but often he gets away with it! Often the landing is painful.

Type number two is a timid approach, fearful, hesitant. It says, "We *hope* you won't mind. We *know* it's dangerous. We'll consider this *awhile* longer." But nothing ever happens. Again we think of another kind of diver who remains indefinitely teetering upon the springboard with arms inscribing graceful arcs but never gathers enough courage

to make the final plunge. Plenty of planning is done, lots of good intentions are formed, but no action results. The course or plan remains in the blueprint stage.

Type number three differs still further. Permission is granted from community and administration, but it is so hampered by fears and restrictions that real confidence is lacking and so real progress is checked. This is the "Yes, my darling daughter, you may hang your clothes on a hickory limb but *don't* go near the water!" approach. "Don't mention sex. Don't mention religion. Don't mention touchy subjects! Don't, don't, don't!"

Finally, there is the reasonably cautious, carefully planned, deliberate approach where confidence is felt because support is present. Here is the diver, mindful of techniques and principles, who leaps with form and grace, without fear and resulting confusion. We tried this one. In our case, it worked.

Increasing Maturity with the Years

So ten years have passed. Certain changes in the type of student body are noticeable. In the first place, the boys and girls come to the course more aware of its purpose than formerly. They are family-conscious, better informed, more "hep." The flood of literature on dating, sex, marriage and child-rearing that has all but swamped the newsstands has had its effect. The students aren't "green" any more. They read articles at home in the apparently innocuous magazines that a wise classroom teacher would be reluctant to handle.

"How do you know it's love?"—
She isn't interested in
such superficialities.

Each year the subject matter has to be elevated to a slightly more mature level. The students are displaying great interest in the psychological and sociological aspects of the family. They are, of course, still concerned with their personal problems and family difficulties, but they are rather fed up with shallow debates on the dating, how-do-you-know-it's-love? type of thing.

They are becoming more observant and less willing to believe all they read, an excellent sign.

Interest in babies and young children is more keen than it was when the course first started. Increasingly, the emphasis leans toward the art of getting along with people. The workings of the mind fascinate them. The demand for reading in the field of psychology increases.

They are conscious of the need for more religious emphasis also.

In brief, Family Relationships has come of age. The many graduates who return with their children have only constructive things to say. They talk of "our course," "our room." Said one graduate, mother of two children, "The further away I get from it, the closer it is to me." This leads us to a final question.

There Is No Yardstick for Results

When shall we begin to measure the benefits from such an experience as this course? One year? Two? Ten? Twenty? *At what period do human beings seize and act upon a principle, a lesson, an ideal, a technique that was suggested to them in their course?* Who knows when the seeds germinate and to what other factors they are related?

No one has given the answers to *those* questions or to *these:*

How many divorces have we prevented or encouraged? We don't know.

How many marriages are happier because of this course? We don't know.

How many premarital pregnancies have we prevented? Encouraged? We don't know.

She can accept the baby more easily, love it more generously.

How much better off are the young parents and their young children because of our course? We don't know.

How much better off will the next generation of children be whose parents *have had* the parents who took the course? We won't ever know.

How many happier homes do we have? More hopeful husbands and wives? More loving and accepting mothers and fathers? We don't know.

We Are Encouraged to Continue

Where then is the proof of the pudding? There is no proof, but feeble evidence of values received may be found in this kind of thing by one inclined to accept it as valid evidence:

- Parental letters of appreciation and parental recognition of positive changes in children.
- Parental comment (unsolicited).
- Parents voluntarily seek guidance, books, pamphlets.
- Parent study groups on family matters organized through PTA efforts use our course as a spark, using our materials and room.
- Citizen interest expressed in class visits, inquiries and "We wish we had had it."
- Continued heavy enrollment.
- Enrollment runs in families—sisters and brothers of the same family elect to take the course. Those families who are *sold* are *sold!*
- Graduates return to express gratitude and appreciation.
- Nurses find it especially helpful in dealing with patients and patients' families.
- Evaluation from married graduates who return with their babies to renew contacts and to express gratitude (*and* to display their progeny).
- Graduates still keep in touch to offer ideas and suggestions and encouragement. Heavy fan mail.
- Community clergy do more marriage counseling. One states that his is directly as a result of his contact with our classes.

Perhaps in time some valid scientific measuring device will be available for us to use in evaluating results. At present where are there such devices for measuring true "value received" from courses in family relationships, history, civics, health or anything else?

Failure . . or Success?

For the present we shall lean on rather subjective evaluation. Maybe we shall have to accept the fact that the value, like beauty, is in the eye of the beholder. To the one boy who said sadly, "It didn't do me any good, because I *still* have problems," it appeared to be a failure. To the girl who wrote, "Thank God for Family Relationships. I would sure have been a mess without it!" it was a howling success.

VENEREAL DISEASE NURSING IN HOSPITALS AND CLINICS

Prepared by a committee of the New York Tuberculosis and Health Association's social hygiene division, including Virginia M. Dunbar, R.N., M. Eva Poor, R.N., Frances L. Boyle, R.N., Dorothy McMullen, R.N., Helen Ratushney, R.N., and Carol May Adams, R.N., in collaboration with Drs. Frank C. Combes, Howard Fox, Evan W. Thomas, Bruce Webster and J. A. Goldberg.

Nursing Knowledge and Skill Are Not Enough

One of the principles of the Charter of the United Nations, incorporated in the Constitution of the World Health Organization, reads: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

All nurses must share in the responsibility of achieving the goal of healthy citizenry. In the management of the venereal diseases, much has been written about the public health nurse's role, but little save that which is concerned with technics of treatment has been done to guide the nurse functioning in hospitals and clinics. Many nurses have not been fortunate enough to have studied these problems in their basic education.

In attending patients with any venereal disease or its complications, the nurse must plan her care with an understanding of all its aspects. Technical knowledge and skill are relatively easy to acquire, but the ability to be of help in other areas needs careful preparation. Teaching positive health is a part of nursing care.

In nursing venereal disease patients, it is essential that the nurses, patients and their families learn to view VD as they do other communicable diseases. Attitudes of nurses are fully as important as manual skills and teaching abilities. Because venereal diseases are closely associated with behavior patterns, the nurse must avoid any tendency to censure, condemn or moralize. It is her responsibility to nurse a sick patient, to serve as the liaison between physician and patient, between the patient and his family, and often between hospital and community.

Patients are often extremely sensitive to the attitudes of their medical attendants. The nurse must understand her patients and their immediate needs. In addition, she requires information about their families, personal and financial problems, friends and occupations. With these and other factors in mind, the patients' conduct patterns can be more readily interpreted, and sympathetic and intelligent nursing care provided.

The Venereal Diseases

The advent of sulfonamides, penicillin, chloromycetin, streptomycin and other antibiotics radically changed the treatment of the venereal diseases. Medical measures are now available which practically make it possible to remove them from the realm of major medical, public health and social problems. And yet overenthusiasm, as well as changing national and international situations, may materially alter the chance of early success.

Recent figures on the number of venereal disease cases reported to the U. S. Public Health Service are indicative of the fact that much remains to be done. A total of 545,111 cases was reported in 1950. Many thousands were probably not reported. The distribution of these cases was: syphilis (all stages), 231,567; gonorrhea, 304,066; chancroid, 5,825; granuloma inguinale, 2,017; and lymphogranuloma venereum, 1,636.

Psychogenic Factors

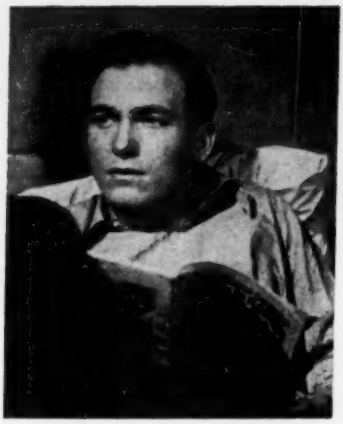
Individualized approach. Psychogenic factors enter largely into the treatment of the patient with a venereal disease. He should be treated as an individual, with special emphasis upon social and economic factors. Various accompanying disturbances present definite problems which can be greatly relieved by the nurse. His possible sense of guilt, inadequacy, lack of group feeling and economic insecurity are entities which must be considered and treated along with the physical effects of the disease.

Fears. More often than not, the patient is fearful and resistive to examination and questioning by those who wish to help him. Accompanying these reactions is the element of guilt which he feels over having acquired the disease. He is often considered an outcast by his friends and associates, and no longer has their sympathy and support. He must live through his illness in a constant state of anxiety and worry.

Emphasis should be placed on the patient's illness as a manifestation which requires objective treatment in order to help him get well. Such an attitude on the part of the nurse, which she subconsciously imparts to the patient, can minimize the sense of guilt and change the patient's attitude toward himself and his associates.

Patients' responsibilities. Emphasis must be placed on cooperation between the patient and those caring for him. The need for such coop-

She doesn't know whether to love or to hate her husband.



eration requires careful explanation by the nurse and understanding by the patient. His willingness to undertake this responsibility entails the giving of information regarding contacts. He should be made to understand this requirement in terms of the health of others who may have been exposed to infection and possibly need medical treatment.

A sense of responsibility must be developed in regard to his own personal hygiene as it may relate to those who are in contact with or are caring for him. These objectives can be achieved through careful guidance and teaching.

Reaction to diagnosis. Some of the psychological complications are often more distressing than the infection itself, from which the patient may actually suffer little discomfort. For instance, the married man who becomes infected with syphilis presents many serious problems which involve his wife and children. If he is in an infectious stage, he must first of all be convinced of the urgent necessity for him to remain under treatment as directed, and to follow instructions to prevent the possibility of his infection spreading to his wife and children.

Other serious difficulties he faces involve not only the explanation to his wife that he became infected but that it is essential that both she and the children, if any, should report to the clinic for examination.

The sense of guilt on the part of the patient and the almost inevitable recriminations with the probable demand by the wife to know the name of the "other woman" add additional tensions to an already troubled

situation. Then there is the fear that not only may the wife have been infected but the child or children or unborn child may also have become involved.

The wife faces a difficult emotional conflict between an instinctive rejection of her husband because of his unfaithfulness and her possible real love for him. Additional emotional problems relate to the possible expensive treatment, absence from work and loss of wages, fear that the employer may find out and that relatives, friends and neighbors may learn the facts.

Problems similar in nature develop if the man becomes infected with gonorrhea or another venereal disease. He may pass on his gonorrheal infection to his wife and she in turn might not become aware of that fact for a long time, if ever. In such a situation, when a husband has been cured of his infection and continues sexual relations with his wife, he could become reinfected by her. He might then unjustly accuse her of infidelity when she would not know that he had infected her originally.

Whatever the venereal disease and whether the chain of infection started with a husband or wife, similar emotional problems arise. It is essential that the consort of either infected individual should be brought in for examination. The task of explaining the necessity for this step must be carefully carried out before a patient is usually prepared to cooperate with those concerned with his treatment.

When an unmarried man or woman is the hospital or clinic patient, parallel problems creating a sense of guilt, fear, recriminations, etc., also need consideration.

Those treating and caring for venereal disease patients are often called upon for advice and guidance on various matters. A proper understanding of the patient's problems is essential if he is to be assisted in adjusting to the disease and resulting emotional involvements.

Sanitary Code Requirements

Municipal sanitary codes indicate the duties of persons in charge of hospitals, dispensaries and other institutions, and of physicians to report cases of venereal disease. All nurses concerned with the treatment of venereal disease patients should familiarize themselves with these legal requirements intended to promote the public health and to prevent the spread of these communicable diseases. Such regulations as these are of particular import:

- It shall be the duty of the manager, superintendent or person in charge of any correctional institution and of every hospital, dispensary, clinic, asylum or charitable institution promptly to report to the Department of Health the full name, or initials, together with the address, sex,

State laws require laboratory tests.

age, marital state and occupation of every occupant or inmate thereof or person treated therein, affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale. It shall also be the duty of every physician in the city promptly to make a similar report to the Department of Health relative to any person found by such physician to be affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale.

• All reports made in accordance with the provisions of this section and all records of clinical or laboratory examinations for or indicating the presence of syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale shall be regarded as confidential and shall not be open to inspection by the public or by any person other than the Commissioner of Health, an authorized representative of the Department of Health and such other person as may be authorized by law to inspect such reports or records, and in addition thereto in Health Department clinic cases the Commissioner of Health or his authorized representative may furnish such information as he deems appropriate to a physician or institution giving further treatment or to a midwife or any agency approved by the Commissioner of Health for the purpose of prevention, treatment or social care. The custodian of any such report or record, the said Commissioner or any such other person, institution or agency shall not divulge any part of any such report or record so as to disclose the identity of the person to whom it relates, except as provided by law.

• It shall be the duty of every physician to furnish and deliver to every person found to be affected with syphilis, gonorrhea, chancroid,

VENEREAL DISEASE SUMMARY CHART

	Syphilis	Gonorrhea
CAUSATIVE ORGANISM	Treponema pallidum.	Neisseria gonorrhea (gonococcus).
TRANSMISSION	Sexual intercourse, kissing, prenatal infection.	Sexual intercourse and ophthalmia infection at birth.
INCUBATION PERIOD	10 to 90 days, average 21 days.	2 to 14 days, usually 3 to 5 days.
CLINICAL SYMPTOMS	*Primary* — chancre. *Secondary* — rashes, mucous patches. *Early latent*—no symptoms or recurrence of infectious lesions after disappearance of secondary lesions. *Late (tertiary). Active manifestations* — cardiovascular, neurosyphilis, gumma, ocular, osseous, visceral, etc.	*Male*—purulent urethral discharge, burning on urination, pain, inflammation and swelling. *Female* — possibly no symptoms. Vaginal discharge, pain in abdomen, salpingitis.
DIAGNOSIS	Darkfield examination, serologic tests, case history, clinical signs and symptoms, X-ray, history and physical examination. Spinal fluid examination in latent and late cases.	Smears, cultures, case history and physical examination, clinical signs and symptoms, contact history.
TREATMENT	*Early*—3 injections of 1,200,000 units of procaine penicillin in oil and aluminum monostearate, injections daily or three times a week. *Late or late neurosyphilis*—600,000 units daily for 15 days or 1,200,000 units 3 times a week for 8 injections.	One injection of 900,000 units of procaine penicillin in oil and aluminum monostearate. This large dosage intended to treat gonorrhea and also abort syphilis when acquired simultaneously.
CONTACT INVESTIGATION	*Primary* case—all sexual partners from date of interview back to six weeks before chancre appeared. *Spouse* — always. *Early latent*—sexual contacts one year preceding and children. *Late latent*—spouse and children. *Congenital*—parents and siblings.	Inquiries for all sexual partners 2 weeks prior to onset of symptoms. For female patients limit inquiries to 3 months prior to clinic visit.

Note: Modifications of the preceding treatment schedules are in use in various hospitals and clinics. Physicians may find it necessary to vary treatment for individual patients.

Chancroid	Granuloma Inguinale	Lymphogranuloma Venereum
Ducrey bacillus.	Donovan bodies.	A specific filterable virus.
Sexual intercourse.	Sexual intercourse.	Sexual intercourse.
2 to 12 days, usually 3 to 5.	Indeterminate; probably 2 to 12 weeks.	5 to 30 days.
Frequent multiple or single, painful, tender, rapidly growing, non-indurated ulceration, ragged edge and dirty gray wet base, swelling in inguinal region, pustule on genitalia and inguinal region.	Beefy, red, granular, shiny, well-defined, granulating ulcer, slowly growing but progressive. Papule on genitalia. Inguinal or perineal ulcers.	Frequently absent. History or presence of a pimple or small ulceration in about 1/3 of cases; bubos; rectal stricture in late stages. Vesicle on genitalia, fistula with pus, inguinal glands and swelling.
Darkfield examination (to exclude syphilis), skin tests (Ito-Reenstierna), presence of Ducrey bacillus, case history, physical examination, clinical signs and symptoms.	Darkfield (to exclude syphilis), case history, clinical signs and symptoms, history and physical examination. Microscopic examination for Donovan bodies.	Darkfield (to exclude syphilis), case history, clinical signs and symptoms. Frei skin test.
Sulfadiazene, 0.5 gm. every 4 hours for 10 to 14 days. Streptomycin, 1 gm. dissolved in 2 cc. distilled water, injected intramuscularly daily for 3 days. Aureomycin or chloromycetin, one 250 mgm. capsule every 4 hours for 4 doses daily, continued for 5 days.	Streptomycin, 3 gms. by intramuscular injection, daily or every other day for 7 doses. Aureomycin or chloromycetin, two 250 mgm. capsules every 4 hours for 4 doses daily, continued for 10 days.	Aureomycin or chloromycetin, two 250 mgm. capsules every 4 hours for 4 doses daily, continued for 10 to 14 days.
Inquiries for all sexual partners 3 weeks prior to date of onset of symptoms. Limit inquiries to 3 months prior to clinic visit.	Sexual contacts 6 months preceding onset of symptoms.	Sexual contacts 4 to 6 weeks preceding onset of symptoms.

lymphogranuloma venereum or granuloma inguinale a circular of instruction and advice issued or approved by the Department of Health, and to instruct every person found by such physician to be affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale as to the precautions to be taken in order to prevent the communication of the disease to others. No person affected with syphilis, gonorrhea, chancroid, lymphogranuloma venereum or granuloma inguinale and no physician treating such a person and no hospital, dispensary, clinic, asylum, charitable or correctional institution where such a person is being treated shall fail to comply with the regulations of the Board of Health or by a negligent act cause, contribute to or promote the spread of such disease.

• Every physician attending pregnant women during gestation shall in the case of every woman so attended take or cause to be taken a sample of blood of such woman at the time of first examination and submit such sample to an approved laboratory for a standard serological test for syphilis. Every other person permitted by law to attend upon pregnant women but not permitted by law to take blood tests shall cause a sample of the blood of a pregnant woman to be taken by a duly licensed physician and submitted to an approved laboratory for a standard serological test for syphilis.

The Interview

It is desirable that the physician responsible for the patient's treatment shall interpret the disease to him; describe the treatment required; explain the importance of furnishing the names and addresses, when possible, of all contacts; and stress the necessity of full cooperation with the physician, the nurse and the social worker.

Where nurses do most of the interviewing and instruction of the patients, the success or failure of an interview will depend not only upon the interviewer's knowledge of the disease but also on her ability to impart this information to the patient in language and terms that he will understand. Often the first contact will set the motivation for the patient's return to the clinic for treatment and follow-up procedures. The clinic organization and the interviewer's attitude toward the patient are important in building up rapport.

The nurse interviewer—if the responsibility devolves upon her—must interpret the disease to the patient; give the name of the disease; advise how it was most likely acquired; explain the causative organism, the difference between the various venereal diseases and why certain procedures will be carried out. It is important to stress necessity for treatment, the amount, type, preparation for treatment on the part of the patient, the need for regularity in clinic attendance, the result the patient may expect from the treatment and the responsibility of the patient not only to himself but to his family, friends and other contacts.

All necessary precautions are to be carefully explained, especially those relating to toilet habits, kissing and sexual relations. The patient should be asked to name his contacts and at the same time be assured that the information will not be divulged. It is important to bring in the contacts for examination and treatment when necessary. If possible, the exact name and address of contacts should be obtained. There may be more than one contact in addition to family and household contacts.

There is also the importance of providing for their treatment as far as time, place, regularity and financial arrangements are concerned. Often a patient will be delinquent because he has to work at the hour that the clinic is held and therefore he should be referred to a private physician or to a clinic which meets his financial and other needs.

The patient gives confidential information about contacts.

At the end of the interview, the *patient* should know:

- The venereal disease he has contracted.
- The treatment needed, where it can be obtained, how much it will cost and clinic hours.
- The importance of regularity in clinic attendance and post-treatment observation.
- The necessary precautions to protect himself and others.
- The importance and desirability of having contacts examined and treated if required.
- The confidential nature of information provided about contacts.
- The interest of the interviewer and other clinic professional staff in helping him achieve an early cure.

At the end of the interview, the *interviewer* should know:

- The patient's address and sufficient identification to trace him in case of delinquency (rent receipt, chauffeur's license, etc.).
- The patient's understanding of his illness and the need for treatment.
- The individual from whom the disease was probably contracted.
- The patient's contacts during the infectious period of the disease and where they can be located.
- The patient's probable cooperation in treatment.
- The patient's need for a follow-up interview.

Contact Investigation

To be successful, contact investigation starts with the infected patient and proceeds cautiously into the home or the community where that person may have acquired the disease and where he may have transmitted it to others. It seeks to discover infection among all intimate contacts. A patient can be expected to withhold information about these contacts because he may be ignorant of the potentialities of the disease.

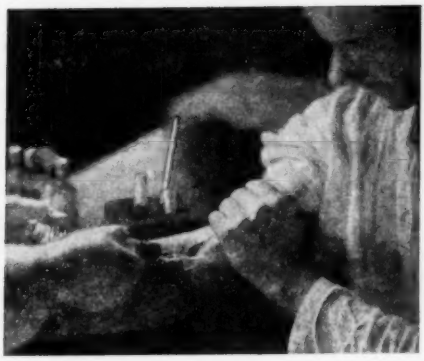
The nurse should be fully aware of them. It is her obligation to inform the patient of the dangers of the disease to himself and to contacts. Failure to participate in this manner in contact investigation is failure to assume a definite responsibility.

The expression "source of infection" carries an implication of accusation and should be avoided in the approach to both the patient and his contacts. The patient should be asked to identify his sexual contacts, naming the last one first and then all the others he can recall. The variation in the incubation period for each of the venereal diseases may result in inadequate information regarding contacts.

Some nurses may think that contact work is actually completed when this reported "source" is found. Yet every infected person is a potential source of other infections. If further transmission of the disease is to be arrested, information must be sought concerning all sexual contacts over intervals selected to include both the stage of active communicability and the incubation period.

Outpatient Department

Venereal disease clinics. With modern and rapid treatment available for many patients with venereal disease, hospitalization may not be necessary provided well-organized outpatient facilities are available. All patients admitted to a clinic should have a serologic test for syphilis. The venipuncture is frequently made by nurses who, in addition to needing skillful technic, should be able to explain why the test is being done.



Nurses frequently make venipunctures.

This is a valuable contribution the nurse can make to public health education.

If the test is reported as positive, the patient should be referred to the venereal disease or syphilis clinic. The nurse can play an important role in creating a pleasant, friendly and professional atmosphere. Whenever possible, the physical set-up of the clinic should provide cheerful waiting-rooms as well as treatment and history rooms with privacy for the patients.

It is the responsibility of the nursing staff or others who are assigned to prepare the clinic for the day's activities. During the clinic session the nurse should collect routine specimens, assist the physicians with examinations, chart essential data, complete records for the Department of Health, give intramuscular injections whenever the attending physicians require her to do so, instruct and give guidance to patients and their families.

A patient coming to the clinic for the first time should be met by the nurse who takes the temperature, pulse, respiration, height, weight, urine, and blood for Wassermann or other serologic tests, unless the physicians do the latter. During these activities she has an excellent opportunity to establish good rapport with the patient by a quiet, interested and helpful manner. A real contribution can be made by the clinic nurse in the field of epidemiology if she utilizes these contacts with patients not only to aid in their examination and treatment but also to help discover other cases.

She should assist the patient to understand his illness, its social implications and the necessity for treatment. If the patient is a woman, the nurse should be present when the physician makes his physical examination.

Subsequent clinic visits may require proctoscopy or lumbar puncture. The nurse will make preparations for these procedures, explaining them

to the patient and assisting the physician in the examination. If the treatment includes intramuscular injections, the nurse follows the physician's orders.

At stated intervals she will collect urine specimens or blood.

Before administering a treatment—if that is standard procedure—the nurse should interview the patient to discover any medical problems or symptoms contraindicating such treatment. If she learns of any, the patient should be referred to the physician before treatment is given.

Admission to hospital. Actively infectious patients may be admitted to the hospital—though many hospitals do not admit such patients—and on discharge should continue their treatments in the clinic. A pregnant woman with syphilis may be treated in the clinic until delivery. After discharge from the obstetrical service, whatever subsequent treatment is required by the mother and the baby can be provided in the clinics. Patients with other venereal diseases may be treated in clinics provided home conditions allow proper isolation during the infectious stages and the patients are sufficiently cooperative and intelligent.

Records. It is essential to keep adequate, accurate records on all patients. A treatment sheet on the chart should give a clear picture of treatments, dates, specimens obtained and laboratory reports. This sheet, accurate and complete in every detail, can be used for a quick review of the progress made, and helps in providing necessary material for reports to the Department of Health.

Cooperation and Accuracy Are Essential

VD clinics must work closely with the local public authorities in the interest of public health. In most states syphilis, gonorrhea, chancroid, lymphogranuloma venereum and granuloma inguinale are reportable diseases. To the nurse may be delegated the responsibility of completing the report forms. These provide the Department of Health with valuable information as to diagnosis, infectiousness, treatment given, age and sex groups involved, increases or decreases in numbers and kinds of cases, geographical incidence, adequacy of treatment and areas in need of more intensive health education and treatment facilities. The reports are signed by the physician in charge.

Specimens of blood may be sent to public and other agencies in special containers. Accuracy in this phase of work is another valuable contribution the nurse makes to research programs to better patient care.

Public health nurse. When a clinic is fortunate enough to have a full-time public health nurse, she will carry out part of the program which otherwise devolves upon the clinic nurse and social worker. Her

function may be solely that of teacher and counselor or she may also follow up contacts and see that they are examined and treated if necessary. This latter function requires real skill, for people are usually reluctant to disclose their contacts. A matter-of-fact attitude and freedom from making the patient feel guilty will help her win the patient's confidence. Should patients lapse in treatment, the public health nurse is the logical person to make a home visit to determine the cause and urge resumption of visits to the clinic.

Problems may arise which might best be handled by the social worker or by various agencies in the community. Not only the public health nurse but all nurses need a good working knowledge of the community resources and should use them wisely in the care of their patients.

Other personnel. Clinic nurses require the assistance of an adequate number of clerical workers and attendants or ward maids. The work done by these groups will relieve the nurse of routines which otherwise would make inroads on her time and prevent her from giving as much attention to the patients as she should. To insure a smoothly operating clinic, these nonprofessional workers should be responsible to the nurse.

Inpatient Department

Isolation technic. Patients requiring hospitalization often have not had a period of outpatient treatment. Consequently, all teaching and reassurance must be done by the nurses on the wards. The same skill and attitude apply, regardless of where the patient is treated. One point of difference in the hospital, as compared to the clinic, is the need for stricter isolation technics when infectious lesions are present. The nurse should promptly recognize that all patients must have this procedure explained to them as early as possible, for they readily develop many fears because of it. It tends to intensify their frequent feelings of being outcasts. Such explanation will help to obviate this hazard.

The duration of isolation is determined by regulations of the Department of Health and the rapidity with which treatment renders the patient's disease noncommunicable.

Case assignment. All nursing procedures require careful explanation and individualized care. It is advisable that the case assignment of duties be used, rather than the functional method. Patients benefit greatly by this procedure since they come to know a few nurses well. This is preferable to trying to become accustomed to many nurses in one day. It is apparent that a nurse will know her patient better if she gives all the nursing care.

Health teaching. All clinic and bedside nurses, as well as public health nurses assigned to venereal disease clinics, should share in the education of the patients in ways of effective and healthful living.

Nursing Care of Patients with Neurosyphilis

Safety of patient. Because treatment of all venereal disease is changing rapidly, specific technics have also changed. However, in spite of advances patients with neurosyphilis are still being seen after inadequate therapy in the earlier stages of the disease.

In the hospital, patients with neurosyphilis may be on the medical neurological ward. When the new patient is admitted, his tense and anxious expression immediately indicates that he needs help in adjusting himself to the general hospital atmosphere. The first requirement is for the nurse carefully and tactfully to explain to the patient's family that the diagnosis will not be divulged to the other patients and that the danger of falling—because of his failing vision or staggering gait—will be minimal. Positive efforts—like arranging the furniture conveniently and safely and having the family bring rubber-soled slippers, which will prevent slipping on highly polished floors—are often of more value than mere reassurance.

A venereal disease patient needs protection from an over-solicitous fellow-patient, from a nurse who may disregard him and from fears that beset most individuals afflicted with syphilis. Careful observation of the patient and knowledge of his home environment and relationships to that environment are integral parts of the treatment.

Most difficult is the problem of protecting and caring for patients in the advanced stages of general paresis. This requires skillful psychiatric nursing without support of the psychiatric environment. Difficult problems are presented when such patients, who are subject to fits of excitement, depression, delusions and hallucinations, have to be cared for temporarily or for extended periods in a general hospital.

The nurse's first thought should be for the patient's safety. Windows must be locked (preferably barred), and any equipment that might possibly be dangerous removed from the room without arousing the suspicions of other patients. Occupational therapy, when available, is helpful in diverting the patient and sometimes even in determining the progress or degree of degeneration.

Patients with tabes dorsalis and other forms of parenchymatous neurosyphilis should receive the same types of protection. Careful instruction of the entire staff is essential. The moral stigma often associated with these diseases is to be avoided. This can begin in the hospital ward.

Fever therapy. Fever therapy has been used extensively in the past but is rapidly being replaced by antibiotic treatment. However, malarial fever therapy may be ordered. It is usually feared by most patients and requires skillful nursing care. Careful explanations by both the physician and nurse are essential. Ideally, the same nurse should attend the patient throughout the treatment.

Psychiatric problems. When psychiatric problems dominate the picture, hospitalization in an institution for the treatment of mental diseases becomes necessary for the patient's own safety as well as that of his family and the community. While this need will be explained by the physician, it often requires interpretation by the nurse. She must be alert to the fear of such hospitals or even to psychiatric divisions within a general hospital.

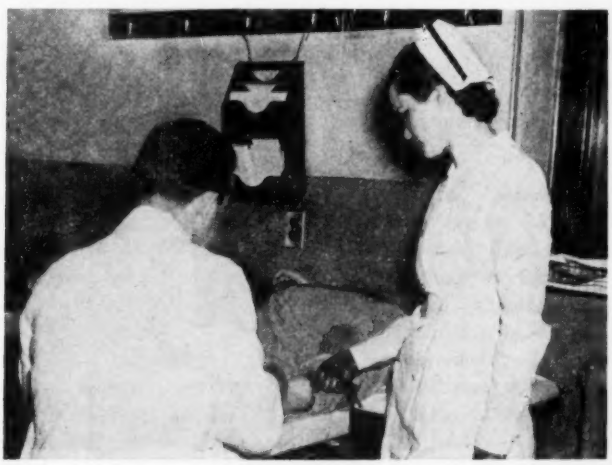
Nursing Care of Patients with Cardiovascular Syphilis

Syphilis is a major cause of heart disease. Nurses may be required to attend many patients with this diagnosis. Skill in caring for individuals with various vascular or cardiovascular diseases is presupposed. In addition, nurses must be prepared to meet the needs created by the fact that syphilis may be the cause. Nursing care is not complete unless the nurse thoroughly understands public health and related aspects of syphilis.

Venereal Disease Nursing in Gynecology

Patients with venereal diseases are also found in those units of the hospital devoted to gynecology. Some patients with a venereal disease, especially gonorrhea, may possibly need radical surgery. Nurses caring for these patients require skill in surgical nursing and a scientific knowledge of venereal diseases, modes of transmission and treatment. Nurses must be prepared to teach the patients in the same understanding and practical manner recommended for those who serve in venereal disease wards and outpatient services.

Sound relationships between physician, nurse and patient will encourage the latter to disclose her source of contact and thus aid in preventing



Sound relationships are important.

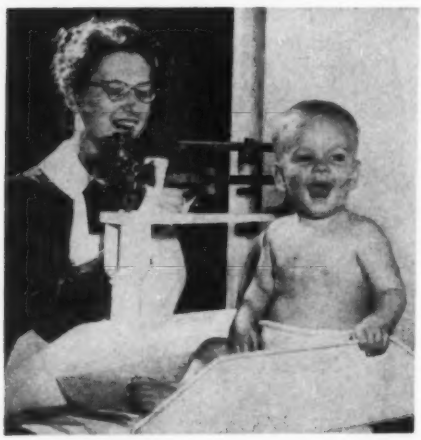
further spread of the disease. Socio-economic factors which become available in good history-taking may indicate some of the contributory causes of infection. These may be related to low intelligence, lack of emotional satisfaction, frustration and other forms of insecurity.

Venereal Disease Nursing in Obstetrics

Every pregnant woman with a diagnosis of venereal disease may now look forward to giving birth to a healthy infant. In states where serologic tests for syphilis in pregnant women are still not required by law, nurses can help to educate the public to demand that such tests should be made and repeated in six months.

Penicillin therapy for syphilis has almost completely replaced the older methods of treatment. This antibiotic seldom causes severe reactions, is easily administered and may be given successfully over a comparatively short time. All these advantages have lessened the fear of treatment formerly associated with older practices. If treatment is given early in pregnancy and relapse or reinfection follows, the patient may be retreated and still deliver a healthy baby. Treatment late in pregnancy will also cure congenital syphilis in utero. The complete eradication of congenital syphilis is therefore a definite possibility.

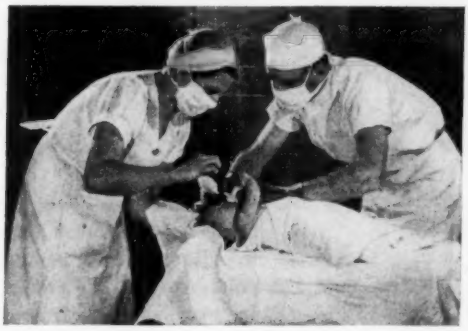
Nurses can be of much help in attaining this objective by taking an active part in instructing prospective mothers regarding the absolute necessity for periodic examinations in order that treatment for syphilis, if necessary, and retreatment during pregnancy may be given. The baby born to a syphilitic mother needs examination periodically, even if symptom-free at birth.



Clinics provide treatment for mothers and babies.

Pregnant women who have been adequately treated for syphilis do not need therapy during subsequent pregnancies. Periodic examinations including serologic tests for syphilis are nevertheless imperative during prenatal care. If these tests are negative, further treatment is not indicated.

Gonorrhea in pregnant women is also successfully treated with penicillin. As a further precaution to prevent ophthalmia neonatorum in the newborn infant, either a 1% solution of silver nitrate or penicillin ointment should be applied to the conjunctivas at birth. Research is still active, and it is anticipated that present forms of therapy may be modified. The important aspect for the nurse is that she should recognize the need for prophylaxis and play an active role in helping to secure it.



The goal of the obstetrical nurse is a healthy baby.

Chanchroid, lymphogranuloma venereum and granuloma inguinale may be safely treated during pregnancy.

Nurses in the maternity field who encounter venereal diseases must be alert to the psychic trauma caused by them. This can be mitigated by helping patients accept the diagnosis as they would that of any other communicable disease. Along with education about the necessary therapy should go reassurance and guidance toward the ultimate goal—giving birth to healthy babies. In addition to participating in therapy, the nurse must also be alert to any underlying social problems. Through education and interpretation of legislative, diagnostic and therapeutic aspects of the venereal diseases, she can make a contribution to their ultimate eradication.

Premarital and postpartum examinations can help in the elimination of many cases of congenital syphilis. The pregnant woman who has syphilis can give birth to a healthy child if she follows the physician's and nurse's advice and receives adequate treatment. Children born of such mothers should be cared for as normal children. The only difference is the need for close and continued medical supervision and preventive measures, including isolation, as long as may be necessary. Such children, like all others, require adequate love, a good diet, proper housing and hygienic care.

There are many thousands of children in this country who have undiscovered and untreated congenital syphilis. According to the U. S. Public Health Service, 521,581 cases of syphilis were reported in 1943 in the United States and its territories. Of the total, 16,582 (3.2%) were classified as congenital syphilis. By 1950 the total of reported cases had declined to 226,942, of which 15,195 (6.7%) were congenital syphilis cases.

Nurses serving in outpatient departments, on pediatric wards, as school nurses or in the public health field, may come in contact with some of these children. It is therefore important to be aware of the symptoms of the disease and whenever in doubt to refer children with such symptoms to a physician.

Summary

Venereal diseases are a public responsibility requiring close cooperation between the physician, nurse, social worker, technician, patient, his family, friends and the community. In addition to knowledge and skill, a healthy attitude toward the problem is of paramount importance if these diseases are to be successfully prevented and treated.

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NEW LIGHT ON THE SEX OFFENDER

Since 1949 when Michigan's Governor G. Mennen Williams asked them to form a study committee on the deviated criminal sex offender, 23 Michiganders have:

- Corresponded with or interviewed 900 persons competent to comment on the sex offender.
- Studied the laws of other states pertaining to the sex offender.
- Studied the case histories of 220 criminal psychopaths, 65 sex offenders on prison parole, and 348 juvenile sex offenders.
- Tested the attitudes toward sex offenders of a random sample of 100 individuals in the general public.
- Recommended new legislation, administrative reforms and activities by voluntary groups.

The Commission's findings formed the basis of a report (published recently in a limited edition) and of a panel discussion during the Michigan Welfare Conference last fall. Sanely presented, simply stated, the findings form a guide for citizen action and agency policies to alleviate the social problems presented by the sex deviate and sex offender.

In the knowledge that human resources are America's top priority, the Michigan laymen and professional workers on the Commission outlined to the Welfare Conference the factors that are vital in any consideration of the sex offender: the emotional prejudice of sexuality, the characteristics of the sex offender, present methods of treatment, the benefits of wise legislation, and the individual's responsibility for the moral and ethical level of our society. Some of their observations follow.

The Emotional Prejudice of Sexuality

by Raymond W. Waggoner, M.D.

It is difficult to change fixed attitudes and ideas about sex. Theories sometimes coincide but more frequently they are contradictory. The Kinsey Report made no mention of psychological aspects. The sex criminal is not the major problem news items would have us believe.

To identify the statutory sex crime with degeneration is inaccurate. (Nearly as many women are killed by their husbands as by sex "fiends.") In actuality, nearly everybody has broken some statute on sex crime at one time or another in his life.

The dynamic approach to sexuality began in the field described as psychoanalysis. There are two basic drives:

- The drive to procreation.
- The drive towards self-preservation.

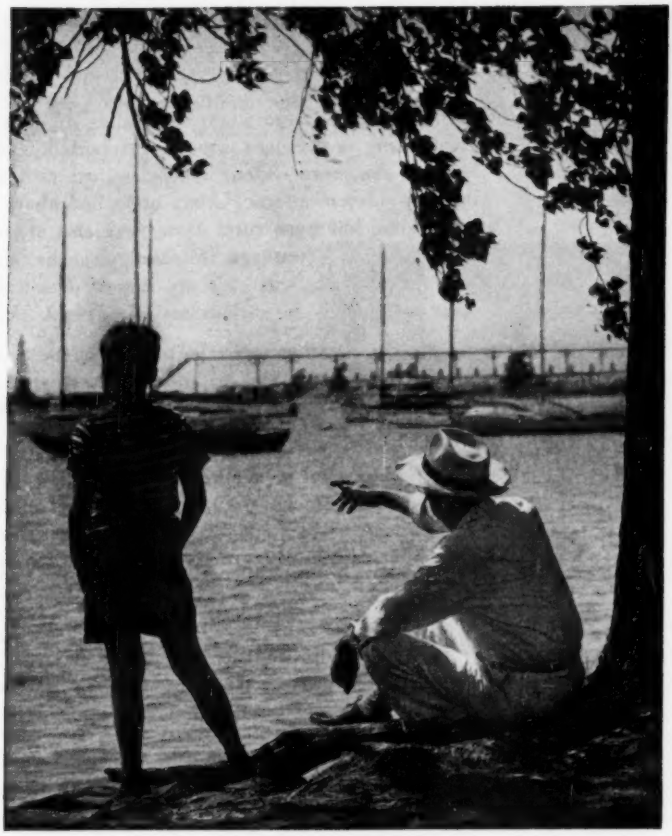
All drives are theoretically based on pleasure, but in sex pathology the common denominator is the kind of stimulation which occurs. For example, physical punishment of a child by a parent may be the stimulus which leads to masochism or sadism.

Sex deviation is exceedingly common, for any sexual activity can be called abnormal which does not lead to bisexual activity. Furthermore, the designation "abnormal" depends on what the group in which a person finds himself considers abnormal. As an example, extramarital relations are accepted by southern Europeans but are not in many other cultures.

The sexual psychopath is something different. He has little or no conscience, an inability to relate to others and a greater than average degree of aggressive sex drive. He can commit an antisocial sex act and have no feeling of guilt afterwards. He is dangerous because he appears on the surface to be able to relate to other people. He shows an exaggeration of the normal drive which exists in everybody, but without consideration for anybody but himself.

Sexual deviation as we are concerned about it is not an inherited trait. It results from a residual disturbance of the psychosexual development in childhood. In each of the three psychosexual phases of narcissism, homosexuality and heterosexuality there is a residual, and some individuals have more residual than normal.

There are two kinds of sexual abnormality. In the individual it shows itself in too much sex drive or too little sex drive. I consider the latter the more important. More crimes are committed by the second group than by the first. The crimes of group two are committed in an attempt to prove the members of it have a strong sex drive, to prove they are "average." The important consideration is the individual toward whom they have this drive.



This father is showing his son the right direction.

Their methods are variable. Exhibitionism is common, so common that I'm not sure it is a deviation. There are voyeurism, sadism and masochism. Some deviations are not dangerous to society and some are.

To boil it down, a sex offender is one who manifests antisocial behavior and gets caught. Often the victim is not a true offender but is made so by the hysteria of those around him.

Security in childhood is the best protection in adulthood against sexual deviation. Sex instruction should be given a child over a long period of time and not in one package. A child gains security when he can approach a parent and obtain healthy sex information. If information is healthily given, a child must eventually think of sex as natural, and a beautiful thing. He should see it in terms of good relationships between and with his parents and then by his own experience.

What the Commission Learned

by Donald M. D. Thurber

In 1948 there were 5,000 complaints of sex crimes in Michigan. A great many sex crimes were not reported. Of those reported, 60% were of the more serious type classified as felonies, while 40% were listed as misdemeanors. Urban areas had above the average of reported sex crimes, but some rural areas were also above the average, including Osceola, Clare, Newaygo, Midland, Isabella and Mecosta counties in Michigan. There was no sharp line of demarcation between urban and rural settings in the seriousness of offenses.

Only 3% of all crimes reported fall in the classification of sex crimes. At the prison level this per cent rises, so that in the Michigan prison population 15½% of the inmates are convicted sex offenders. Taxpayers should be concerned.

In the juvenile population 7% of the boy delinquents appear before the courts on sex charges. It is known that in Wayne County one in six will be back as an adult sex offender. The error is that we fail to intercept what causes later trouble. Investigation has revealed that juvenile sex offenders return before the court twice as frequently in adulthood as other juvenile offenders.

In Detroit three-fourths of those who committed sex crimes against children in a recent year knew the child victim. This gives the lie to the notion of "fiends" jumping upon unsuspecting children.

A fallacy we all share is that sex offenders do poorly on release, for in actuality their record on parole is better than non-sex offenders. Perhaps some of this is due to greater care being given to the selection of sex offenders for release. They are more apt to be required to serve their full sentence than are non-sex offenders. Nevertheless, the fact remains that there are less than half the parole violations by sex parolees than by non-sex parolees. A tenseness develops in the paroled sex offender and a desperate attempt to control his sex drives lest he be returned to prison, but there has been no help for his basic difficulties.

The penalties for sex crimes written in the law were studied and found to have slight deterring power. The conclusion is that a penalty does not deter a crime the cause of which is imbedded in the personality. Therefore, our Commission has decided that we must look to what is happening to children in the molding of personality to see whether the problem under discussion will become worse or better. Estimates are that 3% of our present school children have emotional difficulties, and some researchers have put the number as high as 10%. We must be aware that raw material is building up and sex offenses are sure of continuing.

Another fallacy in public thinking has been the belief that more serious crimes are worked up to by sex offenders who start with lesser sex crimes. "Nip the lesser crimes in the bud before they become more serious" has been the common belief. This is erroneous thinking. Experience has proved there is little likelihood that a sex offender will abandon one form of sex behavior for another.

VD — a penalty the sex offender more frequently has to pay.

These are some of the characteristics of the sex offender, as revealed by the Commission's study:

- He tends to get into more trouble than the non-sex offender.
- He has more difficulty in making a sexual adjustment in and out of marriage.
- He exhibits greater emotional disturbance.
- He has a higher rate of venereal infection.
- He has 20% lower intelligence than does the general population.
- He is twice as likely to be wifeless as are men in the general population.

There is a common thread linking all legal sex offenders and this is the presence of disturbed relationships in infancy and childhood. Fifty per cent come from broken homes, as compared to 20% in the general population. Many offenders were found to have been exposed to cultures at sharp variance with the dominant culture in the area in which they resided as children or adults.

The amount spent on research on this subject has been infinitesimally small. The Commission's general plan calls for the spending of $50,000 of state money in research over a period of five years and in developing clinical treatment and parental and mental hygiene education in child-rearing.

How Michigan Handles the Sex Deviate and the Sex Offender

by Eleonore L. Hutzel

The Commission sent informational questionnaires on resources and practices both to agencies in the private social work field and to those in the official group. The officials answered the questionnaires better. Those in the private field offered enlightening interviews and discussions.

Their Conclusions

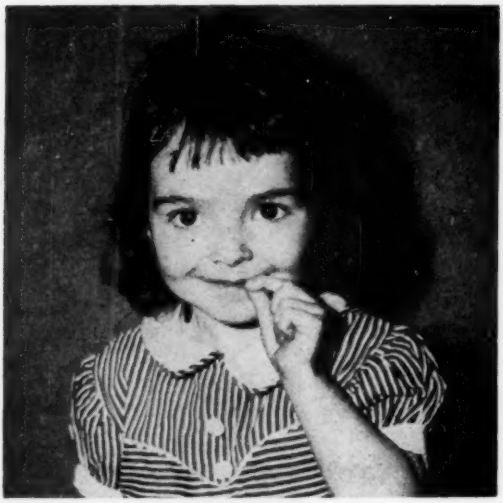
Their conclusions were:

- Sex offenses are not a specific isolated problem. They are part of a general disturbance. In many cases, the agency does not have sufficient evidence on which to base a diagnosis of sexual disorder.
- Resources and present treatment practices vary sharply among the agencies.
- Professionally trained social workers and agencies employing them can most effectively identify sex deviates and prevent sex offenses.
- Resources should be:
  Mental health clinics, inpatient and outpatient.
  Children's guidance centers.
  Private psychiatrists.
  Facilities for the minor personality maladjustments and agencies with specially skilled workers for help with deeper problems.

And Their Recommendations

Their recommendations were:

- That there should be an extension of community mental hygiene facilities (clinics).
- That inpatient services for very disturbed children be increased.
- That outpatient psychiatric services for adults be extended.
- That the programs of adult and children's clinics be evaluated at regular intervals. If they are not giving service to sexually disturbed persons, a special clinic for such should be established.
- That sex deviates be evaluated experimentally to detect elements of treatability.
- That the leisure-time needs of the returned offender be studied and that the recreation activities in the community be reviewed to see if they can meet the needs of those with a potential for negative behavior.



Won't a courtroom ordeal deepen my child's injury?

We know a court trial is a bad experience for a child victim, but it is hoped the procedure can be better handled. In the past parents and social workers have often waived legal action because of the trauma to the victim. Trained people are needed in each police department to help children in these experiences. There is need also for the law to speed up cases and not allow them to drag on. The child and the community would both be better served.

What Legislation Has to Offer

by Hon. James E. O'Neill

The Commission has recommended change in the probate statutes so that selected sex deviates can be committed through the Probate Courts with a view to treating their emotional disturbance, that is, those not to be charged with a violation of the law.

A psychiatric division in the State Department of Correction will offer much if combined with a one-day-to-life sentence. This plan allows treatment if it will do any good. The offenders are detained for sufficient periods so that more can be learned of the characteristics of these individuals. Part of the purpose of the indeterminate sentence is to detect the dangerous potentials, so that they need never be released if they show no improvement.

A great part of the Commission's work pertained to new degrees, definitions and distinctions in sex laws.

The problem of the sex offender is everybody's concern.

The Problem Belongs to All of Us

by Reverend William B. Sperry

The problem of sex offenders belongs to everybody. We are all responsible for the moral and ethical climate in which children grow up. The subject of the discussion is not only the narrow problem of sexual deviation. Happy, well-adjusted persons are not deviated. Anything that we can do to apply mental hygiene principles is our goal.

The Commission advocated:

- Premarital clinics for parents.
- Counselors on family problems within trade unions, businesses, churches, PTA's, etc.
- Resources for the promotion of better mental health. If need be, the development of more resources.
- In-service training in basic mental hygiene for court officers, teachers, policewomen and all other agencies dealing with children.

The chance that the sex offender will repeat is greater if he is not welcomed back into society. Character needs reinforcement so that it becomes easy for both the growing and the mature to say "yes" to what is right and "no" to what is wrong.

BOOK NOTES

Paul Ehrlich, by Martha Marquardt. New York, Henry Schuman, 1951. 255p. $3.50.

In spite of its uncritical approach, this highly personalized biography, full of anecdotes regarding Paul Ehrlich, is stimulating, amusing reading. The author was Ehrlich's personal secretary from 1902 until his death in August, 1915—the period of his greatest accomplishment and of world-wide recognition.

Miss Marquardt manages to convey a remarkably complete picture of Ehrlich's personality, his daily routine in his laboratory and at home, his absent-mindedness, his geniality, his intense devotion to scientific research to the exclusion of virtually every other interest except his immediate family.

One sees the small, slight figure of Ehrlich, cigar box under his left arm, hurrying about the Frankfurt Serum-Institute and the Georg Speyer-Haus, arguing, encouraging, personally directing every step of numerous research projects, incessantly smoking, writing formulas on his stiffly starched cuffs and shirt front, on doors, walls, tables, shouting to his servant, singing off-tune one single song throughout his whole life, cheating himself at solitaire, enthusing over the discoveries and victories of others.

From the beginning of his medical education until his death, Ehrlich concentrated on a specific problem, the investigation of "the idea of a chemical binding of heterogeneous substances to the protoplasm," a field of inquiry which he first defined in his doctor's dissertation.

All that Ehrlich accomplished in immunology and chemotherapy grew out of his study of this limited field. He was accustomed to remark to the numerous young men who worked with him that the human mind is of very limited capacity and one should not fill it up with too great a diversity of materials. This is what he meant by saying he was a "monoman," a one-idea man.

Overlooking the uncritical—not to say adoring—attitude of the author, one could wish that she had dealt a little more fully with Hedwig Pinkus Ehrlich. Those of us who knew Frau Ehrlich feel sure that a person of such unusual charm and warmth must have exerted a great influence over the genius whose discovery of salvarsan was only one, and perhaps not the greatest, of his contributions to human welfare.

CHARLES WALTER CLARKE, M.D.

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How to Be Happy Though Young, by George Lawton. New York, Vanguard Press, 1949. Reprinted from *Senior Scholastic*. 300p. $3.00.

Actual letters written by young people, each voicing a particular

problem, are answered by Dr. Lawton in letters expressing his opinions as modified by the ideas of groups of young people with whom he has worked. These pieces were previously published in *Scholastic.*

The letters, some of which involve *Getting Along with Your Family* and *Getting Along with the Opposite Sex,* are poignant in their sincerity and are answered realistically by the author out of his understanding and psychological insight. Never does he patronize, always he gives kind, wise, reassuring advice to his questioners.

The book should help bewildered young people, parents and teachers.

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Administrative Medicine, edited by Haven Emerson, M.D. New York, Thomas Nelson and Sons, 1941, 1951. 1007p. $10.00.

Reprinted from the *Nelson Loose Leaf Medicine Series,* 1928, this collection of pieces by 57 experts and specialists is more accessible in form than was previously the case.

Individual contributions are grouped under four general categories: development of organized care of the sick in chronologic sequence from its original function of general hospital care of bed patients; services for the sick by institutions of higher education and by the federal government, both civilian and military; structure of public health services from the local unit to the World Health Organization; and a description of special contemporary public health functions in the United States. Chapters have been revised and rewritten and new ones added.

The excellent and authoritative chapter on *Control of the Venereal Diseases* was written by Dr. Charles Walter Clarke, and other chapters refer briefly to this subject.

Since the date for the compilation of VD data is 1947 or 1948, newer developments in this field are missing, such as authoritative discussion of penicillin prophylaxis or immediate treatment of those exposed to VD, of antibiotics in the prevention of ophthalmia neonatorum, of newer evaluation studies in case-finding techniques and of decreased federal allocations. None of these newer developments negate the basic soundness of administrative procedures.

As an authoritative reference, this volume will appeal to a wide audience—physician, board member, philanthropist, government officer and health worker in general or specialized fields.

NORMAN R. INGRAHAM, JR., M.D.

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Problems of Social Policy, by Richard M. Titmuss. London, H. M. Stationery Office and Longmans, Green and Company, 1950. 596p. 25s ($3.50).

As part of the social history of World War II, this study of the evacuation of mothers and children from the cities of England

reveals the changes wrought in the family by the war.

The destruction of homes and crowded housing, working mothers, fathers in service, disorganized school systems, evacuated or working children, a shifting, restless population—all these conditions explain why the formative influence of the home on children's character and moral development was weakening.

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Elmtown's Youth, by August B. Hollingshead. New York, John Wiley and Sons, 1949. 480p. $5.00.

Data on the behavior of adolescents in a typical midwestern town, of rigid social stratification, were collected by the author and his wife from personal, documentary and observational sources.

After a study of the young people and their friends, their conversations and their community activities, the authors concluded that the social behavior of these adolescents was related fundamentally to the social positions of their families. The physical and psychological phenomena of their stage of development were of less significance. Cliques, dating patterns, leisure-time activities, amount of education—all seemed to lead back to family social position.

The poor boy must use his spare time earning money to help support his family, not to date girls, and certainly not upper-class girls. The same is not necessarily true of the lower-class girl. The upper classes are preponderantly represented in extra-curricular activities and high school class offices, but not in the police courts where family position once more wields a powerful influence.

What emerges is a cruel, undemocratic system of class ramification, enveloping every community institution, the school and youth itself, determining youthful social behavior, unyielding because of its hereditary nature.

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Marriage Analysis; Foundations for Successful Family Life, by Harold T. Christensen. New York, Ronald Press, 1950. 510p. $4.50.

Of interest to students and teachers, this book analyzes the problems of marriage, emphasizes the personal relationships of men and women during courtship and marriage.

Once the causes of marital breakdowns are discovered, an effort can be made to adjust individuals and environmental factors. Personal inadequacy and certain elements in modern culture militate against successful marriage.

Divided into four parts, the book covers such material as the similarities and differences of men and women, personality backgrounds, choosing a mate, parenthood and living without a mate.

Each chapter closes with a list of problems and projects to stimulate discussion, and a short bibliography.

The Facts of Life from Birth to Death, by Louis I. Dublin. New York, Macmillan Company, 1951. 461p. $4.95.

This compilation of health facts should prove valuable to biology students, teachers, physicians and social workers, interested as they are in data about population, birth, marriage, health and longevity.

This book is the result of years of research by the statistical staff of the Metropolitan Life Insurance Company.

Chapters on the pattern of marriage, the average American family and marital dissolution are loaded with information in concise form. Answers to questions about VD reveal that mortality from syphilis is four times as high for divorced men as for married men, that there are estimated to be more than 2,000,000 deaths from syphilis in the world annually.

A question - and - answer approach, covering a broad area, ample references according to subject and a detailed index make it easy for the reader to find the answer he wants.

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The Practice of Marriage Counseling, by Emily Hartshorne Mudd. New York, Association Press, 1951. 336p. $4.50.

When someone in a field of service records the results of years of successful experience for the benefit of others, as Dr. Mudd has done in this book, it is always a real contribution. Actual case histories of clients of the Philadelphia Marriage Council and material on the process of counseling are outstanding features of this study.

Here we do not find high-flown *theories;* we find *facts,* practical and successful ways to do marriage counseling.

Her analysis of the characteristics of the clients of the Philadelphia Marriage Council is also challenging reading . . . statistics come to life and have real meaning. Dr. Mudd carefully gives the limitations of her findings, the kind of sample which it represents in comparison to the population of the United States as a whole; she in no way over- or under-rates its value.

The early chapters are devoted to the history of marriage counseling and a survey of functioning marriage counseling services in the United States. The bibliography is one of the best that can be found on the subject, amazingly complete and 19 pages long.

Appendix A lists names and addresses of national and local organizations offering marriage counseling. Appendix B, reporting services dated from October, 1950, to April, 1951, covers their history, staff, clients, methods and philosophy, fee, educational, research and in-service training programs. There are name and subject indices.

The book contains material suitable for college classrooms concerned with training high school

counselors as well as marriage counselors. It has value for the beginning counselor who, although school-trained, lacks experience and confidence. It is a good book for the person who needs marriage counseling either in preparation for marriage or to save a marriage. It is excellent for the civic leader as inspirational reading that might lead to the formation of a marriage counseling center in his community. It has a special appeal for the person who loves to interpret statistics. It is good mental hygiene for anyone who reads it.

The Practice of Marriage Counseling certainly deserves to be in public libraries. It should be classified under "education" for the teachers' section as well as under "marriage," "counseling" and "sex." Its readability, brevity and comprehensiveness should make it a rather popular circulating book.

PAYTON KENNEDY

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Sex Offenses, by Manfred S. Guttmacher, M.D. New York, W. W. Norton and Company, Inc., 1951. 153p. $2.50.

Actually the fourth of a series of the "Jacob Gimbel Lectureship on Sex Psychology," this book is divided into three chapters: *The Problem and Its Causes, Clinical Aspects* and *Treatment and Prevention*. There is an adequate index.

Dr. Guttmacher has accomplished extremely well his announced purpose: "To present this complex and controversial subject from the point of view of the clinician . . . (in) . . . terms that are intelligible to laymen, without being over-simplified." Writing with ease and lucidity, he treats soberly of a topic which only too readily lends itself to sensationalism or conjecture. Certain points are illustrated by well-chosen clinical excerpts and vignettes from his rich experience.

The few faults I found with the book were irrelevant to the purpose for which it is intended.

The insufficiently footnoted bibliographic references impair its usefulness as a reference work. Dr. Guttmacher's 20 years of experience as psychiatric consultant to the Supreme Bench of Baltimore provide a wealth of clinical material, but offer insufficiently detailed study of individual cases to permit adding to our understanding of the psychodynamics of sexual deviation. It would be unfair to consider this as a criticism since Dr. Guttmacher concedes this point and does not take scientific license in "theorizing" loosely beyond the limits of his clinical observations.

In view of the current public hysteria about this topic and the irrational behavior this problem sometimes seems to produce in otherwise objective people, this book is a must for public libraries and for the personal libraries of readers of the Journal of Social Hygiene.

BERNARD A. CRUVANT, M.D.

Your Best Friends Are Your Children, by Agnes E. Benedict and Adele Franklin. New York, Appleton-Century-Crofts, 1951. 310p. $3.00.

A pleasant successor to *The Happy Home: a Guide to Family Living,* this volume does not divorce the child from his family relationships nor set him up as a psychological phenomenon, as do many child-study books. Instead, it sees him as a human being and interprets him to his parents in reassuring, easy-to-understand terms that nevertheless are acceptable to modern psychological insights.

The authors ask parents to see their children as potential friends. To do this, parents must first realize that they, too, are capable of growth and change, and that their adult world is one which their children enjoy sharing.

By concerted action, both parents can accomplish far more than the individual parent to insure wholesome recreation for teenagers. "Boys and girls who have a good relationship with their parents, and whose sexual education has been natural and wholesome, can generally be depended upon to take care of themselves."

The normal parent without serious emotional difficulties will find help and reassurance in the common-sense advice of this book, clarified by means of every-day situations in the average American home.

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Psychological Dynamics of Health Education. Proceedings of the Eastern States Health Education Conference, 1950. New York, Columbia University Press, 1951. 134p. $2.50.

For doctors, nurses, health educators and interested laymen, this book concerns individual motivations that influence the effectiveness of health education.

In his chapter, *Problems of Motivation in Venereal Disease Education,* John A. Morsell recognizes that social hygiene concerns the whole personality, and its accomplishment requires the efforts of the VD educator, whose most difficult problem is getting people to seek voluntarily professional attention for suspected VD. In the interests of economy and efficiency, it is important to keep at a minimum two groups: those who think they are infected when they are not and who must be tested if they request it; and those who are infected but do nothing, whether they suspect the infection or not.

Among other chapters of social hygiene significance are *Adolescence,* by Phyllis Greenacre, M.D., and *The Parent Group,* by Thomas A. C. Rennie, M.D.

HAVE YOU . . .

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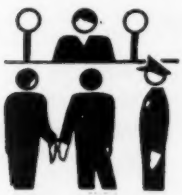
Mailed your 1952 subscription to the JOURNAL OF SOCIAL HYGIENE?

ASHA's recent publications . . .

A-832 How to Develop a Community Family Life Institute.
By P. K. Houdek. Invaluable aid in the planning of an important social hygiene project. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.



A-831 Suppression of Prostitution and Allied Vice.
By Frank H. Fairchild. Outspoken challenge by a prosecuting attorney who cites chapter and verse on what to do about prostitution and what you can do to build a clean community. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-830 Henry VIII and the French Pocks.
By Charles Walter Clarke, M.D. Both high school and college history teachers are using this dramatic story of syphilis' influence on the course of English history. Place copies in your school and public libraries. 15¢ each; $1.50 per dozen; $10 per 100; $70 per 1,000.

A-829 How a Family Grows.
By Rev. F. G. Scherer. This series of talks by a Protestant clergyman makes ideal background reading for a panel on education for family life. Reassuring and inspiring guidance for uncertain parents. 15¢ each; $1.50 per dozen; $10 per 100; $70 per 1,000.

A-828 Civilian-Military Cooperation in VD Control.
By Harry Pariser, M.D. Close liaison between Norfolk's health department and the military makes for better case-finding. Make sure your health officer has a copy. 10¢ each; $1 a dozen; $7 a 100; $36 a 1,000.

A-827 Character Guidance in the Armed Forces.
By Chaplain Martin H. Scharlemann. A chaplain describes the military's approach to the matter of moral training. Good material for a symposium or a round-table including both civilian and military participants. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-826 Sound Attitudes Toward Sex.
By Lester A. Kirkendall. Fine analysis of seven common attitudes toward sex, with suggestions for improving them. 10¢ each: $1 per dozen; $7 per 100; $36 per 1,000.

A-825 The Police Role in Contact Investigation.

By Nicholas J. Fiumara, M.D. How a modern and socially-minded police department can help the health officer. Five years' experience in Boston. Order copies for your health officer and police chief. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-824 Social Treatment of the Sexually Promiscuous.

By Thomas E. Connolly. Will help you evaluate and improve present community resources for social treatment in the courts, law enforcement and welfare agencies, health departments and other public and private organizations. 15¢ each; $1.50 per dozen; $10 per 100; $70 per 1,000.

A-823 Community Responsibility in Family Life.

By Judson T. Landis. Role of the church, physician, health and welfare agencies, schools, colleges and adult education programs. Perfect for a symposium. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-820 National and International Problems in the Control of VD.

By Norman R. Ingraham, Jr., M.D. "VD control in any one locality is dependent in considerable measure on the situation in nearby areas." Does anyone still think the VD problem is solved? 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-819 Interstate Marriages and the Massachusetts Premarital Law.

By Nicholas J. Fiumara, M.D. Discusses recent changes in the Massachusetts premarital blood test law. How does your state's law compare? 5¢ each; 50¢ per dozen; $3.50 per 100; $18 per 1,000.

A-817 Let's Tell the Whole Story About Sex.

By Edward B. Lyman. Four frank dialogues between parents and children on how babies are born, problems of growing boys, menstruation, and the marriage union. Excellent for group discussions. 25¢ each; $2.50 per dozen; $20 per 100; $150 per 1,000.

A-816 In Defense of the Nation.

Brisk resume of accomplishments and problems in social hygiene. *Free* on a first-come, first-served basis.

A-815 Case-Finding Around the Country.

By S. Ross Taggart, M.D., and others. Graphically describes successful educational campaigns in Washington, D. C., Philadelphia, St. Louis and Mississippi. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-814 Education for Family Life; What It Is, What It Isn't, What It Can Be. 17 basic questions and answers, with a suggested outline of general areas in the field of preparation for marriage and family life education. Good speaker's guide. First copy *free;* others $1 per dozen; $7 per 100; $36 per 1,000 while they last.

A-810 The Social Hygiene Movement and Family Stability.
By Eleanor N. Shenehon. Inspiring basic statement for your new board members and others wishing a broad perspective on the social hygiene movement. Free in reasonable quantities on a first-come, first-served basis.

A-809 For the Carriage Trade.
Appealing folder to encourage prenatal blood tests. 5¢ each; 50¢ per dozen; $3.50 per 100; $20 per 1,000; $175 in 10,000 lots.

A-807 Living with Our Children.
By Evelyn M. Duvall. Lists the five essential developmental tasks facing the adolescent. 5¢ each; 50¢ per dozen; $3.50 per 100; $18 per 1,000.

A-806 What's Wrong with the American Family?
By Florence R. Kluckhohn. Challenging discussion of three problems affecting our family system: the confused definition of the feminine role; a faulty and unsatisfactory husband-wife relationship; and a questionable parent-child relationship. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-639 Human Relations Education.
By G. G. Wetherill, M.D. 1951 revision of the San Diego schools' popular outline for the teaching of family life units. 75p. 50¢ each; $5 per dozen; $40 per 100.

A-176 Choosing a Home Partner.
By Newell W. Edson. An old favorite in a handsome new format to appeal to young people. 10¢ each; $1 per dozen; $7 per 100; $36 per 1,000.

A-164 Easy Answers to Your Child's Sex Questions.
Sound information delightfully presented to help parents. Repeated in response to demand for an old favorite. 5¢ each; 50¢ per dozen; $3.50 per 100; $18 per 1,000.

Free in quantity for distribution as you see fit . . .

A-745 The American Social Hygiene Association; What It Is, What It Does.

A-771 The Role of the American Social Hygiene Association
These Tools Are Yours.

A-428 Social Hygiene Films from the American Social Hygiene Association.

A-444 Social Hygiene Pamphlets; A Classified List.

A-453 Social Hygiene Bookshelf (an annotated list revised October, 1951).

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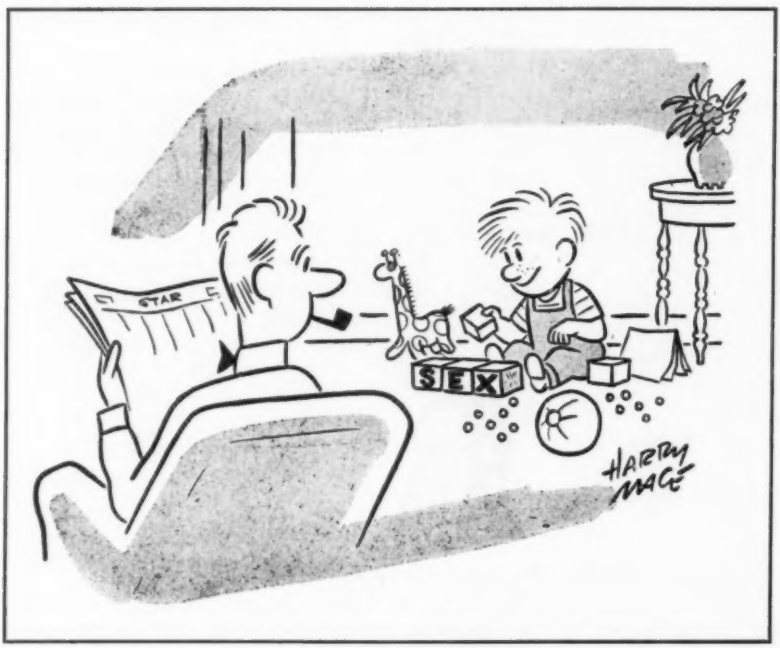

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BEHIND THE BY-LINES

Elizabeth S. Force

Lecturer, writer and a pioneer in the teaching of family relationships in Toms River High School, Mrs. Force did graduate work at New York University and studied under a scholarship with Dr. Popenoe and Mrs. Strain at Mills College. She has taught at the New Jersey College for Women and was course discussion leader at the University of Pennsylvania. Editor and contributor to professional journals, she likes books, music and western ranch life.

Jacob A. Goldberg

Originator of National Social Hygiene Day and director of the New York Tuberculosis and Health Association's social hygiene division, Dr. Goldberg is a New Yorker by birth and education. He received his M.A. and Ph.D. degrees from Columbia University. Secretary-treasurer of the Association of Social Hygiene Secretaries and lecturer at New York University College of Medicine, he is a well-known author, "The Camp Counselor" being his latest book. He and his wife, Dr. Rosamond J. Webster, have two children, Helen and Arthur.

Donald M. D. Thurber

Mr. Thurber is executive director of the Governor's Study Commission on the Deviated Criminal Sex Offender, Michigan, and executive secretary of the Mayor's Committee on the Rehabilitation of Narcotic Addicts, Detroit.

Dr. Waggoner is director of the Neuropsychiatric Institute at Ann Arbor, Mich.

Miss Hutzel was formerly deputy commissioner of the Detroit Police Department.

Judge O'Neill is judge of the Tenth Judicial Circuit Court at Saginaw, Mich.

Rev. Mr. Sperry is rector of Christ Church, Detroit.

The Last Word

The American Social Hygiene Association will hold its annual business meeting in New York City, February 6, 1952, in the Skytop Room on the 18th floor of the Hotel Statler, 7th Avenue and 33rd Street. There will be two sessions:

3:30 p.m. Annual business meeting of members, with reports of committees, election of officers and presentation of the executive director's annual report.

A short program will emphasize the need of preinduction training for members of the Armed Forces and will include a movie, followed by tea.

5:00 p.m. First meeting of the members of the 1952 Board of Directors.

Members may submit suggestions and proposals regarding program, selection of officers and administration of the Association's affairs for referral to the appropriate standing committees and the Board of Directors for study and action.

WINIFRED N. PRINCE, *Secretary*
American Social Hygiene Association

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ASHA's Job in National Defense

★ To study prostitution conditions, particularly near military installations and industrial centers

★ To prepare fully documented reports on local prostitution conditions for the information and guidance of military and civil authorities

★ To provide community leaders with the facts about the dangers of commercialized prostitution

★ To advise communities on the most effective ways of repressing vice and to recommend ways of treating sexual delinquents

★ To stimulate adequate wholesome recreation as a morale-building safeguard against sexual misconduct

★ To intensify the spread of sound information about venereal disease, particularly to young people entering the Armed Forces

★ To help strengthen family life against the tensions of the times by fighting VD and sexual promiscuity, two major threats to family health and well-being

★ To encourage education for family life, through publications, study courses for parents, and formal training for teachers, youth leaders and others who influence young people

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